| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155566 | A. BUILDING **01**<br>B. WING _____ | **04/19/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WARSAW MEADOWS** | **300 E PRAIRIE ST**<br>**WARSAW, IN 46580** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 04/19/16<br><br>Facility Number: 000359<br>Provider Number: 155566<br>AIM Number: 100274920<br><br>At this Life Safety Code survey, Warsaw Meadows was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type III (211) construction in the original building and Type V (111) construction in the northwest, west and laundry wings and all were fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 80 and had a census of 69 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached garage providing storage for the mowers and maintenance supplies, a shed with activity supplies, and a storage pod with | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|---|---|---|---|---|
| K 000 | Continued From page 1<br>wheelchairs, beds and walkers.<br><br>\Quality Review completed on 04/19/16 - DA | K 000 | | |